Information Exchange Workgroup
Draft Transcript
March 30, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the Information Exchange Workgroup call, 10:00 to 11:30. This is a Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. Just a reminder, again, workgroup members please identify yourselves when speaking.

Roll call, Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky. He's here. Carl Dvorak.

Carl Dvorak – Epic Systems – EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter DeVault.

Peter DeVault – Epic Systems – Project Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw.

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman.

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Gayle Harrell. Charles Kennedy. Jim Golden. Dave Getz. Jonah Frohlich.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

George Hripcsak couldn't make it. Seth Foldy.

Seth Foldy – Wisconsin – State Health Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Buehler.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez and Hunt Blair couldn't make it. David Ross. George Oestreich. Kory Mertz.

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tim Andrews. Did I leave anyone off? Okay, I'll turn it over to Micky and David Lansky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome, everyone and thanks for joining the Information Exchange Workgroup meeting today. As usual, we have a pretty heavy agenda. We had a heavy agenda last time and some of that spilled over into this meeting to make this an even more heavy agenda.

What we want to cover today is we want to continue the review of the draft comment letter to the Meaningful Use Workgroup. As I think all of you know, on April 5th they will be having a public hearing to go over the public comments, the synthesis of the public comments that they received on the recommendations that they put out in January. We also, I think want to continue reviewing exchange related objectives—I'm on slide two of the presentation here. Sorry, I'm not following online. So if we could just move the slide forward, please—I want to continue reviewing some of the exchange related objectives, really from an eye towards saying as we think about where meaningful use stage one is and looking ahead to stage two and three, what are some of the higher level objectives we want to be thinking about. Those aren't things we're going to resolve on this call, but I think is certainly a part of what we as a work group want to be able to provide some input on and some guidance to ONC and CMS as they're thinking about this going forward. Then we'll talk a little bit about next steps.

David, anything else to add before we dive in?

David Lansky – Pacific Business Group on Health – President & CEO
No.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
One thought that we had coming out of the last meeting was that perhaps we should have two letters really as we think about what we're able to get through from the public meeting we had and the call. There is still sort of a lengthy list of things that we haven't addressed squarely and just sort of looking ahead at what we might be able to accomplish today on the call and perhaps offline between now and April 5th, which is relatively limited.

We thought that it might make sense to have a first letter that we get in before April 5th just to sort of put ourselves on the map and be able to provide the Meaningful Use Workgroup with that input as they're considering all of the other input that they're getting and whatever else they get at the hearing. Then we follow with a second letter on whatever areas we're not able to get to before April 5th and the line demarcating what would be in the first letter and what would be in the second letter I think really will be determined by how much we're able to accomplish today on this call.

Do people strong feelings about that one way or the other?

Paul Egerman – Software Entrepreneur
Micky, this second letter, I'm not sure— Is that just going to be areas where we get consensus or is the second letter going to describe some areas where there is no consensus? I wasn't clear.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I was thinking that the delineation was just about our covering areas that we're not able to get to. So, I guess to the extent that we have something to say, I mean I guess it would be fair enough to say we didn't get to these three topics before April 5th; now we've considered them, we don't really have anything to say. I guess we could convey a letter saying that we endorse it or not, whatever it is. But it's really more about how far down the list we're able to get, not about parsing them according to the ones that we have consensus on and those that we don't.

Paul Egerman – Software Entrepreneur
Okay, I got it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, well, I think it's a pretty simple process point, so if people are okay with that then I would suggest that we move forward with that plan. So, in terms of the timeline we want to, by the 30th, which I guess is today, want to finalize the first letter and you have a draft of that that Kory sent out this morning where on April 5th there is, obviously, the Meaningful Use Workgroup meeting. I don't believe that we have any formal participation in that. Is that correct, Kory and Judy?

Kory Mertz – NCSL – Policy Associate
Right, yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, that's correct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, and then going back to the ghost of Christmas past for a second, we are still in the process of moving the ILPD recommendations to the HIT Policy Committee. Jonah and Walter and I are going to have a call later today to talk about how to address some of the issues that came out of the last Policy Committee meeting and then to provide coverage for that April 13th meeting because Walter can't make it. But just so all of you in the workgroup know, we will be presenting a revised and hopefully sort of compressed recommendations to the HIT Policy Committee. Since they've been through them once before it was really more an administrative issue in part, that they had only received recommendations that morning, so David Blumenthal thought that that didn't give them enough time to really fully consider them and requested that we just push it to the next meeting.

Then some time after that or in parallel, but with an eye toward sometime in April finalizing the second letter to the Meaningful Use Workgroup, and certainly, everything we've heard from Claudia and Josh and George would suggest that there's nothing magical about our getting it in before April 5th. That's just a good milestone for us to target, but there's nothing magical about that particular date.

So, the draft comment letter that you have was, again, Kory's terrific work in synthesizing what we came to in the meeting and what we're able to put together from the last call. Certainly some issues for further discussion that we weren't able to get to were one is the specific recommendations on medication reconciliation. We didn't really talk about that at all. That's, clearly, a very important area that I think a lot of people have some good perspectives on, so we want to be able to talk about that a little bit.

There was sort of a sense, I think, among a number of members about this generally concept of, I think this is David Lansky's phrase, of putting a down payment on robust exchange. How do we start to think about the pathway to more robust exchange and certainly, what Paul Egerman and the PCAST

Workgroup are doing is part of that conversation, but I think there are sort of a set of things for us to talk about there.

Then there is this one requirement that I don't think we ever fully got to in terms of how to address is this question of perform a test of HIE, which you may remember is a legacy or is a stage one requirement. I think as kind of got revealed in the last call, there's really the need for more clarity on that because even among the members of the workgroup on the call there were different interpretations of what that meant.

I believe the letter, and Kory confirm this if I'm wrong, I think that the letter says right now, expresses our concern that that is not well defined and recommends that it not be put forward in this current state without a better definition.

Kory Mertz – NCSL – Policy Associate
Micky, I actually just took that language out in this version because it sounded like from the last call we wanted to kind of take it a different direction and provide more of a framework that this group thought MU Workgroup should take if they wanted to move forward with that objective.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, yeah, no, you're right; sorry, I forgot about that. I think that's right, there's more work to do on that.

Deven McGraw – Center for Democracy & Technology – Director
Given the amount of stuff that's on our plate, we might consider if we don't quite get to fleshing out what that should look like, at a minimum we should say that it needs to be clarified and shouldn't really be propagated into second stage without further clarification, because I didn't think we were moving it. I thought in stage two we were just redefining what it meant to be exchange, but recognize that we may not have complete agreement on what's actually happening here.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I would agree with that. Do other people have thoughts on that? Okay. So, hearing none, it sounds like for Deven's point that we, at a minimum, want to add back in the letter that they need to clarify that and not, using her words, propagate it in its current form. I'm just looking at the recommendations themselves to see what happened to that particular one. Did it not move it forward in its current form?

Deven McGraw – Center for Democracy & Technology – Director
Yes, I mean for stage two it's a completely different set; it's the establish, connections to three providers or to an HIE and we had a bunch of discussion about whether or not that made it look like you had to join an HIE, which I didn't think it did, but other folks read it that way. Really, to me, in stage two, that perform a test isn't even relevant anymore, but that's the way I'm reading it and apparently that's not a consistently held interpretation.

Peter DeVault – Epic Systems – Project Manager
At the March 15th meeting, we discussed removing this, but trying to maybe replace part of the spirit of it with some more robust use of some of the things that are still in stage two meaningful use, such as maybe using the documents that are exchanged in a more robust way. But I thought it was pretty clear that this didn't make sense to a majority of people in the meeting.

Deven McGraw – Center for Democracy & Technology – Director
Yes, that's my recollection as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, and I think, Peter, to your point, I think you're right, that we did have a discussion that maybe the ability to consume structured documents that were delivered might be sort of an angle on that. Am I remember that right?

Peter DeVault – Epic Systems – Project Manager
That's exactly right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, so maybe we can add some language that at a minimum expresses the caution to not be put forward without greater clarification and then perhaps brings in some of these other thoughts. We can work on that offline, perhaps, and get a letter back out for final approval. I don't know, in terms of process, Kory, are you hoping that we lock down the approval today on this call?

Kory Mertz – NCSL – Policy Associate
No, I don't think we need to lock down approval today. I think it would be good to have kind of the parameters of here's what we're going to lock down language on, as far as objectives or topics and then we can work offline to finalize anything.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, all right. So, maybe if you don't mind just keeping track of these thoughts and maybe we can just follow up on how we address these in language and then get that back out to the workgroup.

Kory Mertz – NCSL – Policy Associate
Okay, yes, sounds good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
On medication reconciliation, you know, as kind of described here I think we certainly know that it's a very complicated process. First of all, do we need a reminder on what it says right now? Maybe that'll help because I know everyone may not have that right at the front of their mind. I don't have the exact language right here in front of me. Do you, Kory?

Kory Mertz – NCSL – Policy Associate
I am pulling it up right now. Hold on a sec. So, right now it says for stage two, "Medication reconciliation conducted at 80% of care transitions by receiving providers, transitions from another setting of care or from another provider of care or the provider believes it is relevant." Then stage three currently says, "Medication reconciliation conducted at 90% of care transition by receiving provider."

Carl Dvorak – Epic Systems – EVP
Is there definition behind conduct medication reconciliation in terms of how we intend it to apply to information exchange? In theory, you can do medication reconciliation. It's actually a process step that wouldn't necessarily require an electronic exchange. It's more or less the clinician reviewing all the current meds that a patient may be on and creating one single list that represents everything that we know of. So, that's really what people know as med reconciliation in healthcare today. Are we going to create some sort of translation that helps them understand with regard to information exchange what's expected of them?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, and I wasn't a part of the deliberations. Perhaps Deven or others who were a part of that can comment, but my sense in looking at the language is that this may reflect kind of the philosophical perspective that the Meaningful Use Workgroup is trying to move toward. Which is to say let's specify clinical outcomes or clinically related outcomes and not specifically specify technology requirements underlying on the assumption that the technology will come along if you, by what you want to do.

Carl Dvorak – Epic Systems – EVP
That's a fair thing to do. We want to be more clear that that's what it's doing is just requiring the process step assuming that it will be burdensome without appropriate technical flow of data and therefore it will drive people to do it electronically.

Deven McGraw – Center for Democracy & Technology – Director
Yes, to be honest, I don't remember the details of that discussion, but that sounds right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, it's at 50% right now. It moves to 80% and then moves to 90%. I mean, I think it's not really even an increase in scope from what I can see. Well, it says perform medication reconciliation, a very simple statement and I would have to look in the definition, but the stage two says conducted at 80% of care transitions by receiving provider, which I would think is what's really underlying that definition at stage one as well.

Peter DeVault – Epic Systems – Project Manager
We also had a discussion at the face-to-face meeting and I think it was my question that brought it up. Whether this is, in fact, referring to transitions of care that occur sort of between healthcare provider entities versus the sort of functional requirement of doing medication reconciliation when you change a level of care within a hospital, for example, and whether the 50%, 80%, 90%. Whatever percentages they are reflect a combination of those things or whether it's really meant to be purely the information exchange between entities?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, I don't know if other people have an immediate thought on that. I did look up—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So, as far as within facility transfers, I don't think that meaningful use has any relevance to that because that's not really exchange outside of the facility. It's already required by Joint Commission when you have level of care changes from ICU just to floor or continuing care hospitals, so I don't think that's really germane to the meaningful use program.

Now, transitions of care between facilities: So if you transfer out of an acute care hospital to a rehab hospital that's a different facility, things like that or when perhaps upon admission to the hospital, those key steps where information may transfer or exchange from a physician's practice to the hospital. I think that where information exchange between different facilities or providers across facilities occurs those are reasonable.

I think we had a discussion at our in-person meeting about somehow making a reference to, maybe not trying to define it at this point in our letter, but making a reference to key transitions in care, because you don't want to try to foist this upon a require that every physician who touches the patient is doing this. What you really want to ensure is that at key transitions from different settings that this is happening and that it can happen as part of the exchange of information.

I think it is certainly reasonable to have that third bullet you have there, that when the care summary is transmitted that there's a complete list of medications. That may not necessarily guarantee that at the transmission of that that every time it's reconciled each time it's transmitted, but certainly the care summary should have a medication list that's accurate and complete.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Yes, thanks, Steve. I think that's helpful and actually, I think it's consistent with— I just pulled up the CMS fact sheet on the meaningful use requirements. The definition for stage one of transitions of care is, "The movement of a patient from one setting of care for emphasis, hospital, ambulatory, primary care practice, ambulatory specialty care practice, long-term care, home health rehabilitation facility to another."

Paul Egerman – Software Entrepreneur
It seems to me it's an interesting discussion about what is the definition of transitions of care, but this is the Information Exchange Workgroup. I think all we're concerned about is whatever that definition is, when it occurs what can we do, or what should we be doing on the issue of medication reconciliation and I like the recommendation, which is let's just say the EHR system is supposed to consume the medication information that it receives in a care summary.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

So, Paul, I actually think what you just said is in agreement; I used a lot more words, but I don't think we should opine on how we define those transitions. I think that's for a different committee. But I agree with you that the EHR should be able to transmit and consume, but we should make reference, I think, at key transition points to be defined by some other facet of the Policy Committee structure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. So, it sounds like really the key issue here then for us is are we comfortable with the trajectory of 50%, 80%, 90%?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Micky, I'd say yes as long as we just make some reference about the need to define what the key transitions are, but not by this group, again.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, okay. Great. Next slide, please. On this question, this came up sort of as a general pulling together some threads of conversation that were happening. David, can I put you a little bit on the spot here and just ask you if you might give some thoughts on this as well because I know you've been thinking about it and I think this was actually your phrase, if I'm not mistaken.

David Lansky – Pacific Business Group on Health – President & CEO
Sure, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I should have asked you in advance, sorry.

David Lansky – Pacific Business Group on Health – President & CEO
Which phrase?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Down payment on exchange, yeah.

David Lansky – Pacific Business Group on Health – President & CEO
That was my phrase, yes. Well, I think the only context for this was the—I know we spent some time on this call in the last couple of meetings down in some of the detailed responses to what the Meaningful Use Committee has put forward as a set of upgrades to the recommendations. We haven't done as much to talk through what we think strategically would be the infrastructure for more robust exchange, other than the directory work. I think, in particular, we've shied away a little bit from the issues of query and other sort of network oriented exchange requirements that some states are going ahead with and we haven't spoken as directly to what the state HIE program is going to do to interface to support the execution of the meaningful use program.

In some ways, I think Paul's work on the PCAST Subcommittee has kind of slipped past us in terms of dealing in great depth with another paradigm and we haven't done as much to really accelerate this presumed paradigm that we're all working on. So, I think whatever we can do to articulate and bring back to the meaningful use process any additional components that would help drive the IE framework is something we should at least consider.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. So, it seems like, in terms of functions—and I know there are some big areas. Maybe one thing we can do is just have a little bit of discussion about this and maybe just make it time limited so we don't spend the entire call doing it. Not because it's not important, but just because we want to get to those other more specific things related to April 5th. So maybe if we give ourselves five to ten minutes to see what people's thoughts are and then maybe I can tee up a future agenda, but the things that strike me, just off the top of my head are—you put your fingers on, David, one—is query response.

Is there a thought toward how we might think about what specific kinds of requirements might be placed that would start to put people on the path toward some type of query response type of functionality? So far in the recommendations, I don't see that really anywhere. The second is—and I think the PCAST Workgroup has been focused on this a lot—is the patient access and the patient's ability to be able to either upload, download their information or have it directed in a structured, comprehensive and routine way into the technology of their choice, some type of PHR or patient-facing application or patient controlled application. Then the third I am going to space out on. Oh, the third is what we already talked about that Peter had mentioned, is the ability to consume, the ability for the EHRs to consume the structured data that's being sent to them.

Those seem like three specific things, at least to me, three specific functional points that I think are a part of the general, robust exchange kind of fabric that you're thinking of or that you're talking about, David, would that be fair?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I think those are very important and we haven't really generated enough directive suggestions that we could put into the process.

Peter DeVault – Epic Systems – Project Manager
I'll take up that same thread. My recommendation was that given that we've got the requirements to exchange care record summaries and we've got some vague requirements around medication reconciliation, it seems like a good step forward would be to try to thread these together into a consistent narrative. Rather than having these be separate sort of independent requirements and actually try to consume the medication data in those record summaries. Then the second thought on this, which came up in a different part of the face-to-face meeting is I was actually quite surprised and through nobody's fault. But my own that we actually didn't have anything in the meaningful use requirements or the meaningful use path that addressed the really common emergency department kind of scenario where you need to query somebody to get a summary as opposed to a kind of push process where you're doing a referral or something like that. It does make sense to me that we have some kind of pathway where we expect emergency departments to at least have the ability to do a query to find a patient's care record summary.

Paul Egerman – Software Entrepreneur
Right. The PCAST Workgroup actually has done that whole, we call it a use case, in terms of exactly what you just suggested Peter of the emergency department doing a query for a patient summary. So, there's an analysis of that and it's sort of in the back—there's a draft letter that describes everything into the back of the letter in Appendix E that said, "Group came to the conclusion that it could not get that completed by stage two of meaningful use." One of the reasons why it came to that conclusion was to do the query response transactions on a national basis requires some policy work and the policy work hasn't been completed, although that wasn't the only reason it came to that conclusion. There were some other reasons also.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Paul, when is that letter broadly sharable?

Paul Egerman – Software Entrepreneur
Well, first of all, let me be clear. What I did was I sent a copy of the letter to Micky and to David to try to make sure that we're on the same page. We're talking about it this afternoon. Today's—I've got baseball analogies—a doubleheader; we've got IE in the morning, we've got PCAST Workgroup in the afternoon and the letter is like your letter, it's a work in progress by the workgroup. So, as I described it the way I did I didn't mean to indicate that that was a final conclusion.

We are hoping to get consensus on the letter this afternoon. I have no idea whether or not we will do that. I can just say that this piece of it that I just mentioned, the ED and the query response, we sent the letter out about a week or so ago and we got a workgroup of about 16 members and I got responses, fairly detailed responses, back from six or seven members and none of them commented on that section.

So, that's just an observation. It could very well be that people who don't like it will tell me that at 1:00. I have no idea.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Certainly appreciate the policy issues related to it. I guess one question is how that gets squared with the fact that certainly in some states they're moving forward with it, again, probably building on the variation that exists out there and that a lot of this is governed by state law whereas meaningful use has got to have a national perspective. But also you have particular places, like I think Peter is just reflecting what he's seeing in the market. I don't want to speak for him, but I assume that's the case, Peter, with your customers and places where you are where they're expressing the desire to have that capability and you're putting your finger on that.

Peter DeVault – Epic Systems – Project Manager
Exactly. Not only the desire, but as Paul and others have mentioned, people are actually going forward and doing it, including our customers, but theirs as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Well, maybe in terms of approach it makes sense to—because we can't cover all of that on this call anyway, but—it sounds like there is going to be a discussion process with the PCAST Workgroup. So we'll have the benefit of seeing where they land on that and then be able to, perhaps, take up the recommendations that come from the letter in a sort of more engaged way by this workgroup at the appropriate time, sometime maybe in the next call or the next call after that.

Paul Egerman – Software Entrepreneur
Micky, what you just said makes perfect sense. What we are hoping to do, trying to do in the PCAST Workgroup is sort of like explain the technology and try to explain how it fits into the ONC programs and strategies. But we also want to like hand it off and just sort of say, well, here's how it fits and here's some ways you can look at it, but then there you go, Information Exchange Workgroup or Standards or whatever; it's not that this workgroup will be permanent. In fact, this afternoon's conference call is supposed to be the very last meeting of the workgroup.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Well, don't sound so happy about that, Paul. No, that's great. That makes a lot of sense. Okay, if we could move forward in the slides here. I think that what we want to do now is actually dive into, I think we already talked about the perform test and HIE issues, so we'll take that up in language and then get that back out in a letter for all of you to comment on. So, we could move the slide again one.

Now, I think what we want to do is dive back into the laborious process that we've been on at the in-person meeting and on the last call of looking at some specific recommendations coming out of the Meaningful Use Workgroup. I believe that with our getting through the medication reconciliation one all of the ones that we're going to talk about now are genuinely new, meaning that they don't have a stage one analog and have any sort of hook back to a stage one requirement. These are all proposed for genuinely new stage two and stage three requirements.

Kory Mertz – NCSL – Policy Associate
Micky, there are still some items in the letter that we haven't had a chance to talk about and then there are some revisions made based on the conversation last time. I was wondering if we wanted to cover that before we jump into the remaining objectives.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure, sure. Since you're familiar with those, if you could just tee those up?

Kory Mertz – NCSL – Policy Associate
Sure. In the letter, which everybody has I did track changes for the changes to submit immunization registry and then syndromic surveillance and then I think we needed to continue the conversation around reportable labs and then need to start the conversation around the new objective about hospital lab

sending results as structured data. Then there is just some language at the end around qualified entities and quality measures. So, we would just want to discuss those, see if we're fairly comfortable with that and want to move forward.

So, just jumping back to the changes around submit immunization data, that was just really including the—we had a long conversation about this on the last call and kind of the desire to include a conversation piece about how standards need to be read for stage three for bi-directionality. And just kind of laying that down as a marker saying, hey, we think this is a good direction, but we want to make sure that people are focusing on that, so added a little bit of language around that. Then also there was this conversation around wanting to have a threshold in stage three for the review of immunization records in the registry during well child and adult visit, so added some language around that as well.

Seth Foldy – Wisconsin – State Health Officer
Seth Foldy here with one proposed modification of the letter language, to see if it's acceptable to the group. In the funding sentence, I'd like to insert the word some, so, "without funding to upgrade their systems some state and local public health agencies may not be ready for bi-directional exchange in stage three," if that's acceptable to the group.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That makes sense to me.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, likewise.

Seth Foldy – Wisconsin – State Health Officer
Thanks, everyone.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Is that it, Seth?

Seth Foldy – Wisconsin – State Health Officer
That was my change on this one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Ooh, we got away easy. Seriously, are there any other thoughts on this? It seems to me that, Kory, you've captured quite nicely a conversation that we had about this. Okay, great.

Kory Mertz – NCSL – Policy Associate
Then on the next one, syndromic surveillance, really the only change was changing the language from express caution to recommending not moving the eligible professional requirement into core and keeping it as menu for reporting syndromic surveillance.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, which I think really reflects the conclusion that we reached at the meeting. Any thoughts on this one?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
I apologize; I've been not present at some of the recent meetings. I know Seth has represented us on this issue. So, this concerns outpatient providers as opposed to hospital emergency departments, is that correct?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Yes, I think I would support that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great, thank you.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Oh, actually, I'm just recognizing something here, eligible hospital; oh, never mind. I'm sorry, confusing the first sentence with the second sentence. This is still okay with me.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. What's the next one? Is it the hospital requirement?

Kory Mertz – NCSL – Policy Associate
The next one was the submit reportable lab data and we kind of started the whole conversation around the concerns about eligible professionals being expected to report. I think we've kind of pushed it off until today, but it seemed like there was generally consensus around the language, but there were some concerns from some individuals as well.

Seth Foldy – Wisconsin – State Health Officer
People have probably interpreted my agreeability on the first two points as reserving my powder for the third and they would be correct. I don't think we have consensus here yet. I would actually point out, I'm sorry that I wasn't quick enough on my feel last time, many hospitals are, in fact, users of outsourced laboratory services and are approaching the reporting of laboratory results using the certification of their laboratory providers LIMS system as the means by which reporting takes place, at least that's my understanding.

It's that concept of having a LIMS system certified as part of an EHR was accepted by ONC. I think we would find that there are some, although I do not know if it is many, hospital providers that might be going that route. Therefore, while I'm sympathetic, as a primary care physician, to the plight of physicians here, I'm not sure that there isn't actually a pretty straightforward path that would make the eligible provider similar to a fair number of eligible hospitals. I know that our goal today is to figure out where we have consensus and where we don't and I would be willing to move this into the we don't have consensus yet pending further discussion rather than trying to achieve consensus on the call. But I would suggest that we don't yet have consensus about the language.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
I'd like to just raise an additional point. It's important as a matter of context to keep in mind that the mandated report of a notifiable disease may be triggered by the laboratory results. For many diseases, it certainly does include the laboratory result, but the full report, virtually, always requires additional information besides the laboratory test result that diagnoses a particular condition, such as the demographic information or other clinical information. Sometimes it's not just a positive lab test that makes the determination that the patient has a reportable condition.

There may also be requirements of certain clinical manifestations or other laboratory tests that might indicate the presence of disease. For example, with hepatitis A you need laboratory evidence of recent hepatitis A infection, but there's also a requirement that that's accompanied by either clinical signs of jaundice or other laboratory evidence of liver dysfunction. And that information is needed to complete the report or classify the patient within a category of hepatitis A disease.

So, much of that information that's needed, for example, if the laboratory reports a positive test, there's still a need to complete the report to go back to the clinician to get additional information about the patient and much of that information is in the electronic health record. So, as a general issue I think we would want to foster the full process of the required reporting through the EHR. Obviously, the focus we've had

on the laboratory report is important. That's often the critical trigger that initiates the process, but I'd hate for us to lose sight of the broader dimension that goes with this mandated reporting.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Can I just back up for a second? So, thank you for that Seth and Jim. Seth, I agree with you. I think that we don't yet have consensus on this. So, just to frame this, first off, just to remind everyone it seems to me that there are two issues here that may be separable and may be not, but just to remind everyone of what the language says right now and it's a little bit convoluted. I'm just going to read directly what it says. I know that's not our problem that the language came through the way it came through, but it says, "EP lab reporting menu." I'm not really sure what that means, but it says, "For EPs insure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law)."

Seth Foldy – Wisconsin – State Health Officer
I think we all agree that the language is convoluted and sub-optimal.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, right. I think we then subsequently made the recommendations to clear it up with respect to, I think we parsed out two things. One was this question of, and not necessarily as just required by law. In some places, it's not necessarily required by law, but it's required by other things, so there was some language right there. The other I think was to separate out the conditions.

Seth Foldy – Wisconsin – State Health Officer
That's right and I think we've had two schools of thought on talking reportable labs versus reportable conditions. The two schools of thought are to remove mention of reportable conditions all together or, perhaps, to take it out of the reportable labs row and make it its own row so that it can be explicit and clear what we are talking about, which at this point we are not.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Just to add to that, there are some instances when the reporting laws mandate reporting on the basis of suspicion of a case of disease, particularly for certain infections that would prompt a very aggressive public health investigation. That report is mandated by law to occur even before the laboratory result is available if there is a reasonable clinical suspicion for certain infections.

Kory Mertz – NCSL – Policy Associate
I just want to hop in for a second. One point of context that I think will be helpful in this conversation, one of the objectives we haven't gotten to yet is a public health button. That includes the reportable condition, so I think that's one of the reasons I think we could potentially remove it from here, because it's still going to be covered in that other functionality area. So, I know we've kind of lost that connection of those two points, since we haven't gotten to that objective yet, but I think that's one thing people should keep in mind.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, and I think the public health button, though is a stage three, right?

Kory Mertz – NCSL – Policy Associate
Well, I think right now they only have language on stage three and they're saying, it's one of those ones where they're asking what do we need to do in stage two to get there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Kory, I think that's a great point and it leads to the question that I was going to ask, because it seems that if we parse these; let's just talk about the direct because it says, "that the physician is responsible either directly or to attest in some way that their performing lab is doing it." So, the first is, let's leave aside the conditions question for a second, but if we talk about directly that would then lead to a certification requirement, I would think, that the EHR systems be able to do the necessary analytics to decide what's a reportable condition. Is that correct? How would that work?

Seth Foldy – Wisconsin – State Health Officer
I guess similar to a hospital EMR, it should not, in fact, be different I think than hospital EHR certification requirements. I'm not sure there's a reason why it would have to be different.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess I'm not that familiar with how that works. Maybe Peter or Carl, I would love your perspective on this since you've got systems on both sides.

Peter DeVault – Epic Systems – Project Manager
The question is what would this require of an EMR system?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yeah, exactly. If this is going to be a stage two requirement that says that the physician ought to be able to directly do reportable, submit reportable lab data to public health. That will almost certainly lead to a certification requirement and I'm wondering what that looks like on the technology side.

Carl Dvorak – Epic Systems – EVP
I'll jump in, too. It seems that the physicians directly themselves wouldn't typically be used to being responsible for that element of it. It seems like most of the places that are, even above just small offices, have that built in already in different other process steps around their lab system. So, it's more of an organizational requirement I think than an individual physician requirement, isn't it?

Seth Foldy – Wisconsin – State Health Officer
But I believe that the EHR, well there's a series LOINC and SNOMED code, and we're actually working on upgrading that table to make it more complete and more machine readable, that would trigger an electronic message using the HL-7 251 public health reporting messaging standard. So, the goal is primarily to automate that portion of the reporting process.

Carl Dvorak – Epic Systems – EVP
How would the requirements that come down to the individual doc? I guess we'd have to measure what were the occurrences of a reportable condition and did that get reported or not? Again, for most practices that will be a support function, but we'd still try to figure out then per doctor who was involved, did the organization report that result or not and then if the doctor had failed to do it, then their EP status is impacted, right?

Seth Foldy – Wisconsin – State Health Officer
So, again, the two situations, the situations where ambulatory practices outsource their laboratories, which I'm suggesting could potentially be handled the same way as when hospitals outsource their laboratory so that it would be through a conjoint certification of the laboratory system. Then there are going to be some situations, as we've talked about, where ambulatory practices are generating lab results internally. In that situation, and I'm not sure I'm the best expert on this, but the EHR system or the LIMS system deployed in that practice would recognize a certain set of LOINC and SNOMED codes and say, oh, this is one for our local public health reporting catcher. Send the message.

Carl Dvorak – Epic Systems – EVP
It feels like the vast majority of tests are run in some sort of LIMS; I know that certain back offices tests are run manually and then just directly keyed into an EMR sometimes, but it's a real small minority as we've experienced it. I just wonder if that may be a lever for something like CLIA and not necessarily for our program here.

Seth Foldy – Wisconsin – State Health Officer
I have started to try and investigate that and it looks a little problematic. But, again, what I think I've realized since our last meeting is that there's actually a very active parallel that's in place for eligible hospitals that is almost identical to this. Remember, this would be a menu item, if I'm not mistaken for stage two for ambulatory clinicians because it's not even a menu item today. It would cause the

outsourced laboratory providers to begin to upgrade their LIMS systems to send messages in precisely the same stream as hospitals, precisely the same catchers in public health.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Let me just ask one question. Is the intent, Seth—because you keep distinguishing between labs that are done and I don't want to put words in your mouth. But it seems to me that what you're suggesting strongly is that the only cases in which a physician or let's say a practice or an ambulatory entity to Carl's point, I still think it's hard to figure out how this would work its way all the way down to the EP responsibility. But let's just say the entity, that the only case in which they would report directly would be for labs that are conducted by them within their practice and the assumption being for labs that they get from other places, whether it's a hospital or Quest or whoever, that they would be attesting in those cases. Is that correct?

Seth Foldy – Wisconsin – State Health Officer
Well, again, when a hospital outsources its laboratory work my understanding is that they are having their laboratory partners certified and are attesting to their laboratory's work.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, I think in most cases when a hospital outsources it the results come back to the hospital system. They do the reporting through their own system, as if the lab was conducted on their own premises.

Seth Foldy – Wisconsin – State Health Officer
It's my understanding that ONC has been asked this question and did specifically state that a LIMS system could be certified as being part of a hospital's EMR. But this may need to be investigated, actually.

Carl Dvorak – Epic Systems – EVP
Micky, I think you're trying to differentiate with Seth the difference between the small set of tests that a hospital doesn't run internally and sends out to a reference lab because they have more machinery. There's a slice of those that then come back into the hospital lab system and then from the hospital lab system back to their EMR or CDR. That might actually be different than a hospital who chooses to outsource the entirely of its lab operation.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, fair enough.

Carl Dvorak – Epic Systems – EVP
There is for that spectrum there in the middle as well.

Paul Egerman – Software Entrepreneur
Also, I think there's another case—I agree with what Carl just said that people might be confusing when we talk about the laboratory information system, which is a lot of hospitals have basically purchased a completely separate laboratory information system for their lab. They will certify that as a module and that's completely allowed under the way certification works and it's actually, I don't want to say, frequent, but it happens a lot. There are a lot of laboratory vendors out there they will certify their lab systems and they'll be one module that a hospital will use, but it's still part of hospital certification.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right. So, I would just say that I remain still not supportive of requiring individual clinicians to attest to a different third party that is not themselves doing something through the meaningful use program, whether it's in the menu or otherwise. I think that the things that are in the menu need to all still be reasonable requirements of the individual clinician or their organization doing those activities so that they're all reasonable. Not necessarily an area where we put aspirational things that are not under the direct control of the physician or the clinician, as it may be because it's more than just physicians.

For laboratory stuff, if they are performing certain tests the results of which are required to be reported to public health agencies then current law or regulation will already require that they report those things. I think one of the challenges that we have as we try to design the electronic world for healthcare is we are doing some things without a full appreciation for just how heterogeneous healthcare is delivered across countless different specialty settings and sites of delivery of care. We then cause real downstream problems that I don't think if we knew them all we would want or intend to cause.

So, I would say that it's reasonable to require large laboratories to comply with the law and then perhaps report electronically if they're not currently. It's also very reasonable to try to require vendors to have the ability for their software products to send and receive structured laboratory data and things like that, but I don't think it's reasonable to start requiring individuals through the meaningful use program to attest that other third parties are somehow doing this. I think it's a diminishing return to try to go into the individual clinician setting at this stage and try to require that they somehow are also doing what big laboratories are doing, not that it's not desirable. I think it's just an overreach at this point.

Seth Foldy – Wisconsin – State Health Officer
Arguing the counterpoint, I'd simply say that the effect of this inclusion would simply be to—well, not simply, would be to drive all EHR systems, certified EHR systems, and certified LIMS systems, which is the approach that many are taking to a single standard of how they pop the result over to public health without much fuss or bother. That if one part of the community is held to a certain standard and the other part of the community is not, then we start creating heterogeneity in the products we're purchasing and installing.

Carl Dvorak – Epic Systems – EVP
I don't know if I'd agree with that. What you might consider is to create a definition that says for the test that the eligible physician performs and records independently, that those tests must be submitted to public health if they are, in fact, reportable. I just worry that it's, again, one of those indirect levers. You're trying to require an eligible physician to ensure that a third party acts in a certain way when I don't even know how they would go about properly verifying to attest. I could see if you wanted to make the requirement it might still have your desired effect. Make that requirement only for the test that the EP actually physically performs on their site and that those must be reported because those must be reported because those would be a set of tests that, in theory, might go unreported, if not for requirement.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Can I ask just a clarifying question of Seth or Jim; are the reportable conditions, is that a national standard or does it vary by state?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Each state has this independent authority to declare what's notifiable within its jurisdiction, although there is clearly a lot of overlap, there are variations. The states get together through the Council of State and Territorial Epidemiologists and agree on a set of conditions that they deem nationally notifiable that the state's share information with CDC.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, it's that subset that we're talking about here?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Yes, that's a pretty large subset of what may be reportable in an individual state, but it's not the entire set, though. But we are at CDC trying to come up with a single source of truth about if you're in jurisdiction X, here's what you report, here are the codes you're looking for, so that process can be simplified. It won't be a single list because state law and state regulation and local law and local regulation apply, but we're trying to get to at least a single acceptable source of truth.

Carl Dvorak – Epic Systems – EVP

And we have pushed standards; in other words, states get together and agree on common case definitions, so the lists may vary from state to state and there are some subtle differences, but I think Seth's point is well taken that there's a lot of core similarity.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, I'm going to suggest that we just spend one or two more minutes on this because we've got a couple of other things to talk about. But it seems to me that really all the perspectives, and I think all of the facts, the relevant facts, have been batted around here. It seems to me that we have sort of a genuine difference of opinion among workgroup members about a couple of the points, so maybe the letter just ought to reflect that. I guess I would try to parse it a little bit to say—and I think this builds on Carl's point and on Steve's point—to parse out the reporting of things that are done within their own practice to suggest that perhaps their consensus in the workgroup that those things ought to be required if they're done within their practice. I guess to Steven's point, maybe that's a little bit redundant or sort of belt and suspenders because it's probably required by law anyway, but if that's the case then maybe it's okay to have it as a requirement. But it seems like where the disagreement is on this question of attesting to or having to report things that are done out of your system.

Seth Foldy – Wisconsin – State Health Officer
So, two things: First of all, each of these criteria represents usually a measurable threshold and for, I would warrant, 99% of the outpatient practices in the United States. If we set the threshold at 50% or 60% it would readily be met by their commercial lab provider fraction and without having to force the issue about the individual attests performed inside an individual practice setting. That being said, and then the issue about attestation, again, we would probably need some input perhaps by other federal agencies like ONC and CMS. But it's really not clear to me why simply the provision of a rider clause on your contract with your lab provider, that is to say the laboratory here certifies that it will meet the requirements of meaningful use on behalf of this provider.

Carl Dvorak – Epic Systems – EVP
In that case, would the provider then, as they attested for meaningful use, only be required to attest if they had the clause or would they be required to attest as to the outcome of whether or not it happened or would they be responsible to verify and report on the fact that it happened appropriately?

Seth Foldy – Wisconsin – State Health Officer
Again, this is a good question, but I would imagine they'd say my laboratory provider that provides more than X% of my tests has been certified; it tells me in our contract that they've been certified and that they are submitting, or something to that effect.

Carl Dvorak – Epic Systems – EVP
I guess I would lend my support to Steve in this in that it feels like it is not really related to a provider's meaningful use of an EHR and it's more a laboratory processing requirement and it should be pursued through other vehicles, unless we're really specifically talking about what that provider does.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Can I suggest that we move—? We don't have to reach consensus on everything and I think that as a workgroup, if everyone is in agreement with this, that we note that this is an area where there is genuine difference of opinion in the workgroup. I would think that our job as the workgroup is to articulate the sources of the difference of opinion, but reflect that there really are differences of opinion.

Seth Foldy – Wisconsin – State Health Officer
And would we relegate this then to the second letter, as we try to clarify what we do want to say?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's a great question.

Seth Foldy – Wisconsin – State Health Officer

I would suggest that because I think that there are a few issues here where I could try and craft some language and we could hammer until we get to as close to a consensus as we can and then elucidate areas of disagreement where they may still exist.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. How do other workgroup members feel? I think that's a good suggestion, actually.

Deven McGraw – Center for Democracy & Technology – Director
That sounds good to me.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, and maybe we can devote a … to it. Seems like it needs it.

Deven McGraw – Center for Democracy & Technology – Director
I fear it would come to the same conclusion. I think you're right. We have to report a difference of opinion on this, but it's good to hash out what the issues are in something more official to the Committee.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, great. Thank you. That was a very thoughtful exchange and also got us really to the heart of what the issues are that I think we have differences of opinion on. So, let's move now to some of the new requirements; oh, no, we need to talk about the hospital one, that's a big one. If we have to put certain things in the second letter, I think maybe it can be the one we just talked about as well as some of the new requirements, but the hospital recommendation is clearly a big one and I would we'd want to get there for April 5th if we can. So, Kory, if you can just walk us through that.

Kory Mertz – NCSL – Policy Associate
Oh, sure. So, the kind of general language we put in right now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
This is on page three of the draft letter.

Kory Mertz – NCSL – Policy Associate
Right. So, the language, based on the conversation at the in-person meeting we crafted this language together, that for an MU requirement it would say, "Require hospital labs to electronically send lab results in a structured format to providers for more than 40% of labs sent." And then getting at this discussion we had around how we wanted to target this to really a subset of labs, you know the most common subset of labs, having those be coded through LOINC. So, I think that's what we're trying to get at in this language, but I don't know if people feel like we got there or not, but this was kind of our first stab at how to represent that whole conversation about really seeing this as a key area we wanted to push forward.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I think certainly, though, that lays out the concepts that I think that we had pretty good consensus on, or pretty good agreement. You either have consensus or you don't, but we had pretty good agreement on. We'll decide whether we have consensus, so first off we should test that and then second, do we have the specifics right as written here. Maybe we'll just take the first point; is everyone in agreement that we want to have a requirement for hospital labs to electronically send lab results in a structured format to providers and we can talk about whether 40% is right and then the second is about the certification requirements for the LOINC subset.

Peter DeVault – Epic Systems – Project Manager
I'm in agreement with that.

Paul Egerman – Software Entrepreneur
I would agree. I think you that's just on the first point, so the first point, yes, I agree.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

I also agree.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, and 40% feels right?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Egerman – Software Entrepreneur
I have a question. Is it 40% of labs sent or 40% of providers, what is the 40% of?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It says labs sent.

Paul Egerman – Software Entrepreneur
I just had a, maybe it's too technical, but what happens if you have one provider who represents half your labs or maybe represents 80% of your labs and they don't have a computerized system? What does the hospital do then?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, I guess it would be 40% of labs that are electronically sent, right? That's the clarification you think we should put in? Yeah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I mean, 40% of labs that are electronically sent are electronically sent?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, sent in a structured way, sorry.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
In other items we've had some kind of where available kind of clause.

Paul Egerman – Software Entrepreneur
Yeah, there's got to be something there, right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. So, first off, Jonah, to your point, it's about structuring, it's about the structured format, not about sending them electronically.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. But if they don't send any electronically, then they're off the hook.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Paul Egerman – Software Entrepreneur
But we want them to send it electronically whenever they can. Basically, the real goal of this is to get more electronic exchange of laboratory data to the physicians, especially to the small physician offices, directly into the electronic record. That's the real goal. So we want them to do it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, but the other lever on this is the demand side that I think that the structured labs requirement is moving from menu to core.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Micky, I'm agreeable or supportive. I mean, we do want the labs to be sent in structured format, so I'm supportive of that. I think we have already talk about maybe, what, a hundred tests comprising 90% or more of the universe of frequently used tests, so I don't really have an argument one way or the other on the 40%, although I think a hospital perspective would be interesting.

I guess the interesting challenge is, this is another example of what the hospital does varies widely depending on its setting. So, in a major urban area where there may be things like Quest and LabCorp, the outpatient community may make good use of those, the physicians. If you're in a rural hospital, that may be the only show in town. So, at my community hospital I have no idea what percent of their total lab volume is outpatient. So, I'm assuming that this requirement does not include labs ordered, generated and consumed internal to the hospital, right? Because an acute care hospital probably generates the greatest volume of its laboratory services for its own internal use.

So, would they fulfill this requirement if their lab information system and their clinical information system, which are probably two separate software programs, if everything that's ordered internal to their institution and consumed in the acute care setting is also then exported to their own clinical information system and recorded in their EMR in a structured format? If that's 70% or 80% of their total lab volume, do they meet the requirement or is it only for whatever that fraction is that is ordered for essentially outpatients coming in for outpatient testing ordered by a community clinician?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, I think the intent here was that this really be a lever to push the structuring of lab data pushed out to the ambulatory side. But I guess I would put it to the workgroup to suggest that we want it on the inpatient side, too, but is that a separate thing that we have to consider or do we bake that in here somewhere?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think it begs for clarity.

Peter DeVault – Epic Systems – Project Manager
I think regardless of how that ends up being clarified, the LOINC requirement is still important.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, so that one is separate. Is it just that we do so, on the MU requirement here do we just want to specify that all we're addressing is the outpatient business that they do and remain silent on the inpatient or do we want to say it applies to both? If we say that it applies, that it covers inpatient, too, then we do have to resolve this issue of can people, not intentionally, but could it essentially just be fulfilled by delivering it on one side and then not doing anything on the other side?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I'd almost think you'd be better off to somehow reword that. It says that what you want to do is require hospitals to electronically generate, store and utilize 40% of all of its lab data in a structured format and almost be silent on whether it's ambulatory or inpatient. Because the goal is ultimately to get all the labs, regardless of the site of production or use to be in structured format, right? Or at least the broad universe of things that are commonly used, so is there a way to make it so that's just 40% of all laboratory results generated by hospitals will be in structured format, able to be transmitted and received?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess one way of locking, maybe this is overly prescriptive, but one way of just making sure that there's not sort of gaming that happens is that you could say that we want it to cover both and it should be 40% on each side.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Yes, I guess I'd be fine with that. That's consistent with just saying 40% of all, yeah.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, but it's allowing that you want the segments to have at least 40% as well and not have it be asymmetric, completely asymmetric.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right, so you could just say for more than 40% of laboratory and inpatient labs generated.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Or, electronically sent, well, yeah. It seems that the goal, one of the big goals here in terms of a big gap area is the outpatient side. We're telling physicians that they need to have this stuff structured, and we're telling the EHR vendors that they have to be able to receive it according to a structure. But we haven't placed anything on the source systems to say that you need to send it out structured and recognizing that we don't have any levers, any immediate levers over the commercial labs, but wanting to be able to do something with the hospital labs.

Paul Egerman – Software Entrepreneur
Just a thought; for the 40% internally wouldn't that already be covered, in a sense, by the earlier structured lab, incorporating structured lab objective, or am I not understanding that?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that's only an eligible professional requirement, so it's only an outpatient requirement.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Micky, can I mention one trivial thing? But I would just suggest in the support of the paragraph underneath that it is deleted, that comment it is estimated that 70% of clinical decisions rely on lab results. I don't know where that came from or how it's substantiated, but I think that's a far stretch.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think it would be a lot cleaner if, given that there seems to be some overlap potentially with some other measures on the inpatient side, like CPOE, and since we're really trying to emphasize and align the levers on outpatient lab results reporting, we should probably limit this just be about outpatient labs.

Peter DeVault – Epic Systems – Project Manager
I guess I'd be fine with that if we're only talking about the structured reporting part and not about the LOINC code. I do think we need to get people using LOINC and that's important both in the hospital and outpatient.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, that makes sense. I think we can have them applied in two different ways. I think, Jonah, I think you raised a good point—and you always raise good points—but we don't know, there might be some unintended consequences with this bumping up against other hospital objectives or requirements, if we broaden it to that. So are people okay then with we'll tighten up the language to say that this is for 40% of the labs sent on the outpatient side with the caveat that it only applies to those that they're sending electronically so it does give them that protection and then the LOINC codes would apply generally to all labs? Okay. Great.

Kory, were there any other open issues from your perspective in the letter?

Kory Mertz – NCSL – Policy Associate
Well, so if we want to talk about the language around qualified entities and quality measures or if we just want to move on and put those in the second letter? I think we can go either way on that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I mean, this is more sort of a general kind of thing, isn't it, which is really related, I think, if I'm not mistaken to some of the putting the down payment on health information exchange sort of concepts that we had talked about before, if I'm not mistaken. I mean there are no specific meaningful use requirement or anything related to the qualified and the question that's forcing that question right now.

Kory Mertz – NCSL – Policy Associate
Right and it's more timed to the perform a test of HIE, so if we're not going to get that in this letter, it probably makes more sense to move this language to the later letter as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's what I would certainly suggest. How do others feel about that?

M
I agree.

Deven McGraw – Center for Democracy & Technology – Director
Yes, me, too.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Then the quality measures language, it's just that one paragraph kind of summarizing our discussion.

Paul Egerman – Software Entrepreneur
I have a comment about this. What we're saying is we like quality measures, right, and we're saying we want to put the pedal to the metal on the quality measures. But we're also saying we want robust information exchange and it seems to me if you're going to emphasize something you probably have to de-emphasize something else.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm not sure I understand—

Deven McGraw – Center for Democracy & Technology – Director
Yeah, me neither.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
—the trade-off there, but I guess I would say just to one point in general that I'm not sure that we need to have this quality measures language in here right now. I'm not sure it says anything yet.

Paul Egerman – Software Entrepreneur
Yeah, I could agree with that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yeah, but certainly we should think of it within the context of the broader information exchange discussion. I think that's probably what you're getting to, Paul, is that right?

Paul Egerman – Software Entrepreneur
Well, it's part of it. The other part is separate there are discussions about what can we really get accomplished and state to meaningful use and when are we going to start it and people are feeling, in the industry, feeling overwhelmed. So I just think we've got to be careful when we say we want to do robust information exchange, we want to do robust quality, we want to do robust everything. You can't do everything.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I see. Okay, it sounds like there's agreement to take the language out right now and then probably want to hear some language at the end that refers to a second letter that's coming, yes. Then, Kory, we can work offline on the language that we were talking about on all these changes, but I think you've been keeping track of them.

Kory Mertz – NCSL – Policy Associate
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Great. Are there any other things? Well, there's only ten minutes left, so I would suggest that we probably don't want to dive into any of these new requirements.

Deven McGraw – Center for Democracy & Technology – Director
Yes, that makes sense, Micky. It's Deven. But I was glad to see that some of the potential technology and policy issues raised with respect to the patient portal. We in the tiger team—well, actually more in our tiger team planning calls amongst Paul and I and Joy—talked about what issues might need to be teed up from a certification standpoint. There's some that are on the privacy and security side, but others that are just about portal functionality and usability that are probably better nested in information exchange. At any rate, I'm glad to see it on the list and you might even, if you take a look at the tiger team material for Friday, at the very end of one of the documents see some of the stuff that got teed up.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, okay.

Paul Egerman – Software Entrepreneur
Although, when I looked at it in the slide presentation, which I guess maybe I shouldn't have, but when I did I saw an indication that you might be also considering moving data from the PHR to the EHR. Did I see that right or not?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are you talking to Deven?

Paul Egerman – Software Entrepreneur
I'm asking you, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Oh, well I think that there is a recommendation that came from the Meaningful Use Workgroup that said something about submit—well, there's one that is about submitting patient generated data to public health, which is an interesting one for an EP. Which I guess the suggestion there is that patient generated data, oh, here, "There's an implement capability to upload patient generated data," I assume that means into the EHR.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, that's an old one. I mean that's actually been around since the Meaningful Use Workgroup set a recommendation for stage one projected out to stage three.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, now it's in stage three and then there is another one that is somewhat related, which is submit patient generated data to public health. I guess the implication is it's been uploaded to you as an eligible professional and now you are supposed to report it to public health. I assume that's going to be a pretty hot conversation around some of those topics.

Paul Egerman – Software Entrepreneur
Okay, thank you for clarifying that. I misunderstood what it said in the slides, but now I understand it, so thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
All right, so we'll take those up in our next call. Just before we turn to public comment, Kory or Judy, do you know when our next call is, just so everyone has it on the calendar.

Kory Mertz – NCSL – Policy Associate
It's April 8th.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

April 8th.

Kory Mertz – NCSL – Policy Associate
Yes, and we're definitely going to need to schedule a few more to finish these conversations, because that's the only additional one we have on the books right now.

Judy Sparrow – Office of the National Coordinator – Executive Director
Micky, when are you back from your holiday?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I will be back Monday morning. I'm just gone Thursday and Friday.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, I'll send you a few dates.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Well, I think we're ready to open it up for the public comment then.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if anybody wishes to make a public comment.

Moderator
We have no comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Operator. Micky, I guess that's it. So, thank you all very much.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. Thank you, everyone.